Health Safety Net Provider FAQ

Frequently Asked Questions about Health Safety Net (HSN) Regulations, Eligibility, and Billing

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Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

CONTACT INFORMATION

For Providers:

MBR Questions:
Contact 888-665-9993, the central number of the MassHealth Enrollment Centers.

Virtual Gateway Application Questions:
Contact the Virtual Gateway Help Desk at: 800-421-0938.

Health Safety Net (HSN)Help Line:
Contact the Division of Health Care Finance and Policy Help Line: 877-910-2100.

Pharmacy POPS
ACS Technical Help Desk at 1-866-246-8503

Pharmacy Prior Authorization and Utilization Review
Drug Utilization Review Program at 1-800-745-7318

For Patients:

HSN Help Line: 877-910-2100.

To File a Grievance With the HSN:

To file a grievance, the patient should send a letter to:

Division of Health Care Finance and Policy
Attn: HSN Grievance
Two Boylston Street
Boston, MA 02116

The letter should include, at a minimum, the patient's **name and address**. If possible, it should also include information about the situation, the reason for the grievance, the **provider's name** (if a provider is involved), etc. The more information that the patient gives, the better. It is very important to include the provider's name if a provider is involved.

Questions about filing a grievance should be directed to the HSN Help Line at:
877-910-2100.

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1. APPLICATION QUESTIONS

NEW

1.1 Application Overview

1.1.1 Application Process

Patients may apply for medical benefits from the Commonwealth of Massachusetts either through a paper Medical Benefit Request (MBR) or through the Virtual Gateway. Individuals who are determined ineligible for both MassHealth and Commonwealth Care are screened for Low Income Patient status, and, if so determined, are notified by MassHealth that they are eligible for the Health Safety Net (HSN) to pay for their eligible medical services. Patients who are Low Income Patients can be found in the REVS system.

As of October 1, 2007, minors seeking confidential services (see 1.1.7) may apply for HSN eligibility using the electronic Free Care desktop application. The Division is currently developing an Application for HSN Confidential Minor Services. Once the Application for HSN Confidential Minor Services is released, providers must use this application to apply for HSN eligibility for minors seeking confidential services. This application will be available through INET.

1.1.2 MBR Requirement

The MBR can be used as an application for HSN, MassHealth, and Commonwealth Care. The MBR processes patient data through the MA-21 system so that an applicant's determination is statewide and viewable on REVS upon determination. An MBR must be used if the patient refuses to sign the Permission to Share Information (PSI) form.

1.1.3 Applications at Home

Providers can hand out or send a paper MBR to the patient and instruct the patient to return the completed form directly to the MassHealth CPU. Alternately, providers may direct applicants to return the application to the provider and the provider may then send the application to the CPU. The provider should *not* use the application to fill out an application via the Virtual Gateway using the information on the form.

1.1.4 Applications with No Social Security Number (SSN)

Individuals may still apply for medical benefits even without an SSN. These individuals may still be eligible for certain MassHealth programs, and/or be determined Low Income Patients. These patients will appear in REVS.

1.1.5 Age 65 and Older Population

Virtual Gateway applications and paper S-MBRs determine MassHealth and HSN eligibility for the Community Elder population. By using this application, a patient aged 65 or older may receive a MassHealth or HSN determination.

1.1.6 Asset Test for Applications Over 65

HSN determinations do not require an asset test. However, to apply for the HSN, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine MassHealth eligibility but does not factor this asset information into the HSN determination.

1.1.7 Confidential Minor HSN Applications

For minors that require confidentiality, Low Income Patient status can continue to be determined using the Free Care desktop application. Providers must collect documentation of the patient's request for confidentiality and keep this documentation (such as a signed affidavit or letter from the patient) in the patient's file with the HSN application. For minors applying confidentially, HSN will pay only for services related to family planning and sexually transmitted diseases.

If a minor requests confidential services and is already known to the MassHealth system (e.g. the family includes MassHealth members, or the family had MassHealth eligibility within the last year), MassHealth has processes for ensuring that the patient can receive confidential services without the family being notified. The MassHealth Enrollment Center should be contacted; a separate Free Care application is not necessary.

In the case of minors who are covered by a private insurance policy but require confidential services, it should be noted that, in these cases, using the MassHealth system does not ensure complete confidentiality. These patients should continue to use the electronic Free Care application to ensure that claims are processed confidentially.

As of October, 2007, the Application for HSN Confidential Minor Services is in development at the Division of Health Care Finance and Policy. When this application is released, the Free Care application may no longer be used.

1.1.8 Confidential Applications for Battered and Abused Individuals

Battered and abused individuals seeking services may apply for HSN confidentially using their own income information. These individuals should apply using the Virtual Gateway or an MBR. The Free Care desktop application should not be used for applications for confidential battered and abused individuals.

1.1.9 Deceased Persons

If possible, a MassHealth application should be submitted within 10 days (for the under 65 population) or 90-days (for the over 65 population) from the date of death. Medical expenses

leading up to the death are billable to MassHealth if the applications are completed within this period. An additional DDU Supplement form may be needed for individuals who were not otherwise categorically eligible – death is considered a disability for the purpose of this application.

1.2 Required Income and Residency Documentation and Verifications

1.2.1 Residency Requirement & Verification

Low Income Patients must be Massachusetts residents, In accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, it will be assumed the applicant is a non-resident and MA-21 will terminate the applicant's Low Income Patient status.

1.2.2 Homelessness & Residency Verification Process

The MBR and Virtual Gateway common intake forms include an indicator for homelessness that enables complete processing of the application and prevents homeless MassHealth members or Low Income Patients from being terminated due to a lack of residence.

1.3 Affidavits, Virtual Gateway Processes, and Partial Deductible Calculation

1.3.1 Pending Virtual Gateway Applications

If a patient has a VG application submitted, but no determination has been made and this patient presents for services at another facility, this patient's status is "pending." S/he should not submit another application. The provider can contact the original provider where the application was completed to inquire about its status. The provider can also contact the MEC at 888-665-9993 to check on the status of an application.

1.3.2 MassHealth Income Affidavits

MassHealth rules of necessary income documentation apply for all Low Income Patient determinations through the MA-21 process.

MassHealth considers affidavits "reliable evidence" for income documentation only as a last resort when no other documentation is available. If an applicant claims no income, then under MassHealth rules, no documentation is required, and the application will be processed as it is currently for MassHealth applicants with no income.

1.3.3 Seasonal Workers & MassHealth Income Calculations

For these applicants, a filed US tax return is the best form of documentation because it shows annual income. If a seasonal worker provides pay stubs, the income calculated will be higher

than the worker's actual income. A letter from the employer is also valid and is considered appropriate documentation of variable income.

1.3.4 Deductible Calculation for Partial HSN

HSN patients whose family income is over 200% FPL must incur a partial deductible before the HSN will pay for their services. The Partial HSN deductible is calculated as follows:

[Gross family income – (200% FPL)] x 40% = annual deductible

Example: for a family of 2 with income of $41,076 (300% FPL using the MassHealth income guidelines)

($ 41,076 - $27,384) x 40%= $ 5,476.80

2. ELIGIBILITY QUESTIONS

NEW

2.1 HSN Eligibility Determination: The Basics

2.1.1 Overview of Low Income Patient Determination

Patients may apply for medical benefits from the Commonwealth of Massachusetts either through a Medical Benefits Request (MBR) or through the Virtual Gateway. Individuals who are determined ineligible for both MassHealth and Commonwealth Care are screened for Low Income Patient status, and, if so determined, are notified by MassHealth that they are eligible for the Health Safety Net (HSN) to pay for their eligible medical services. Patients who are Low Income Patients can be found in REVS.

The exception to this requirement is for minors seeking confidential services. Providers may continue to submit applications for these individuals using the existing electronic free care application. When the Application for HSN Confidential Minor Services (currently in development) is released, providers must use this application for confidential minors.

There are three categories of eligibility that Low Income Patients may receive.

- Low Income Patients with Health Safety Net – Primary are between 0 and 200% FPL and have no other health insurance coverage. The HSN is the primary payer on their claims.
- Low Income Patients with Health Safety Net – Secondary are between 0 and 200 % FPL and have other health insurance coverage. They are eligible to have their reimbursable services paid for by the HSN if the services are not covered by their primary insurer. Patients enrolled in MassHealth Standard, Basic, Essential, CommonHealth, and Family Assistance/Direct Coverage are not eligible for HSN – Secondary.
- Low income patients with Health Safety Net – Partial are between 201 and 400% FPL and may or may not have other primary insurance. If a HSN – Partial patient has other insurance, the provider must bill that insurance for the patient's services before billing the HSN. HSN – Partial patients must meet a deductible based on their family income before the Health Safety Net will pay for reimbursable services provided to them.

2.1.2 Length of Eligibility Period

Low Income Patient status is maintained for a period of one year, beginning on the start date as determined by MassHealth (i.e., 10 days prior to the date the MassHealth application is received). For Low Income Patients other than those eligible for Commonwealth Care, MassHealth Basic, or MassHealth Essential, and other comprehensive MassHealth programs (see section 2.1.3), a provider may bill the HSN and receive payment for services rendered up to six months before the date of determination. These Low Income Patients must comply with the MassHealth re-determination process and requirements.

For patients eligible for Commonwealth Care, MassHealth Basic, and MassHealth Essential, HSN temporary eligibility will begin 10 days prior to the patient's application for benefits and end 90 days after the patient's application for benefits. During this time, the patient should call to enroll in Commonwealth Care or MassHealth. The "date of application for benefits" refers to the day that a complete application is received by MassHealth. The income information in the application must be complete in order for the application to be processed by MA-21. The only exception to this standard is information regarding the applicant's citizenship and identity. An application may be processed without this information and will be assigned a start date of the day that this application was received without this information.

After 90 days, patients who are eligible for Commonwealth Care may still call to enroll in a Commonwealth Care plan, even though they are no longer eligible for the Health Safety Net. They will not need to re-apply for health benefits. Once the patient enrolls in a Commonwealth Care plan, the patient will have HSN eligibility between the time they enroll and their plan coverage start date.

2.1.3 Portability and Proof of HSN Status

If a patient's Low Income Patient status is determined through the Virtual Gateway or the paper MBR, it is portable – that is, it is applicable at all acute care hospitals and community health centers in Massachusetts that participate in the HSN. Any provider can go into REVS and check patient status.

2.1.4 Eligibility Rules for Eligibility Determinations Prior to 10/1/07

The new regulation is for **dates of service** 10/1/07. Even if a patient was determined prior to the regulation effective date (10/1/07), the eligibility rules in the new regulation apply for all dates of service after the regulation effective date, regardless of when a patient's eligibility determination was made.

2.1.5 Eligibility Rules for Application Dates Prior to 10/1/07 that are Determined after 10/1/07

Example
9/1/07- MassHealth application submitted via the Virtual Gateway.
10/1/07 Application determination is still pending
10/4/07 Patient is approved for MassHealth Standard with an effective date of 8/22/07.

HSN eligibility on dates of service before 10/1/07 for this patient would be determined by the previous regulation. Therefore, this patient would be eligible for 6 months of retroactive eligibility from HSN. Providers could also bill the HSN for eligible services offered to this patient that are not covered by MassHealth Standard. For dates of services on or after 10/1/07, the eligibility rules of the new regulation will apply to this patient.

2.2 HSN Secondary Eligibility and Temporary Status

2.2.1 HSN Eligibility for MassHealth Members

MassHealth members with comprehensive benefit packages (MassHealth Standard, CommonHealth, Essential, Basic, and Family Assistance/Direct Coverage) are not eligible for HSN (with the exception of patients eligible for MassHealth Basic and Essential who receive temporary HSN eligibility for up to 90 days before they are enrolled in a plan). Members of all other MassHealth programs have HSN – Secondary eligibility. Providers may bill the HSN for reimbursable services not covered by these MassHealth programs.

2.2.2 HSN Eligibility for Patients Enrolled in Commonwealth Care

Commonwealth Care members are not eligible for full HSN Secondary. As of October 1, 2007, the HSN will pay only for dental services that are not covered by a Commonwealth Care member's plan.

2.2.3 Commonwealth Care Eligible but Unenrolled Patients

Patients who are eligible for, but unenrolled in Commonwealth Care are no longer eligible for HSN. When a patient is determined eligible for Commonwealth Care, the patient will be given 10 days of retroactive HSN eligibility and 90 days of temporary HSN eligibility going forward from the date of application. Individuals who enroll in Commonwealth Care will also be eligible to have services paid for by the HSN from the date of enrollment (which is the day the Connector receives the patient's payment) until the date that their Commonwealth Care coverage begins. If the patient remains unenrolled after 90 days, HSN will no longer pay for services provided to that patient until the patient enrolls in a plan.

2.2.4 Access to Affordable Private Insurance

Beginning in April 2008, individuals with access to affordable employer sponsored insurance or other affordable private insurance will not be eligible for HSN – Primary. Once an individual enrolls in a private insurance plan, he or she will be eligible for HSN – Secondary. Commonwealth Choice plans and Young Adult plans are considered private insurance for these purposes.

2.2.5 Resident Students and HSN Secondary Eligibility

Every full-time and part-time student enrolled in a certificate, diploma or degree-granting program of higher education must participate in a qualifying student health insurance program (Q-SHIP) or in a health benefit plan with comparable coverage as defined in 114.6 CMR 13.04. Students are not eligible for HSN – Primary.

Students must be enrolled in a Q-SHIP plan in order to be eligible for HSN – Secondary. Students may apply to be determined Low Income Patients, and providers may bill the HSN for services not covered by other insurance.

2.2.6 Age 65 and Over & HSN Secondary Eligibility (QMB, SLMB, QI-1)

Individuals with eligibility in the MassHealth Buy-In categories, including Senior Buy-In (QMB), Buy-In for Specified Low Income Medicare Beneficiaries (SLMB), and Buy-In for Qualifying Individuals (QI-1), have Medicare and also have family incomes of less than 135% FPL. Therefore, they are also eligible for HSN Secondary for HSN Eligible services not covered by Medicare or their MassHealth aid category. HSN will pay for prescription drugs for Medicare Part D members in the Medicare Part D "donut hole."

The HSN will always be the payer of last resort and will only pay for services not covered by either program.

2.2.7 MassHealth Basic and Essential Eligible but Not Yet Enrolled Patients

Patients who enrolled in MassHealth Basic or MassHealth Essential are no longer eligible for HSN. When a patient is determined eligible for one of these programs, the patient will be given 10 days of retroactive HSN eligibility and 90 days of temporary HSN eligibility going forward from the date of application. After this time, HSN will no longer pay for services provided to the patient.

2.2.8 Citizenship and Identity Pending Period & Low Income Patient Status

Individuals who have been unable to verify citizenship and identity but who have otherwise completed an application for medical benefits will have HSN eligibility until their citizenship and identity is verified.

2.2.9 Patients Exempt from the Individual Mandate

If an individual is exempt from the individual mandate, the individual has no access to state-subsidized health insurance or affordable insurance through the private market. Therefore, this individual is eligible for the Health Safety Net as long as his or her income does not exceed 400% of the FPL. The individual will need to complete an MBR application.

2.3 Benefit Programs and the Health Safety Net (EAEDC, CenterCare, Healthy Start, CMSP, etc.)

EAEDC

EAEDC provides coverage for emergency physician services at a hospital, all services provided at a CHC, and certain other services. Reimbursable services not covered by MassHealth for this population may be billed to HSN. Providers must make every reasonable effort to have EAEDC

patients enroll in MassHealth and document all such efforts. Most EAEDC patients are eligible for MassHealth Basic and may enroll in MassHealth without submitting an MBR / Virtual Gateway common intake application. These patients should be instructed to call the Health Benefits Advisor at 800-841-2900 to enroll. If an EAEDC patient has an EAEDC card, but does not appear in the REVS system, a new MA-21/VG application will need to be completed for that individual for them to be eligible to receive healthcare benefits. EAEDC patients should only be instructed to call and choose a PCC if they appear in REVS.

Family Assistance – Premium Assistance

Patients with Family Assistance –Premium Assistance are also eligible for Health Safety Net – Secondary.

Healthy Start

Healthy Start offers coverage to pregnant women up to 200% of the federal poverty level who do not qualify for MassHealth benefits except MassHealth Limited. Pregnant women meeting the eligibility requirements will be approved for Limited and Healthy Start simultaneously.

Providers must check REVS to determine patient status. Individuals approved for Limited / Healthy Start after July 1, 2004 will be listed on REVS under the coverage type: **LMTD HLTHY STRT**. Eligible women approved for Healthy Start before July 1, 2004 will not have their Healthy Start eligibility listed in REVS. If REVS displays LMTD HLTHY STRT as the coverage type, providers may bill the HSN for Eligible Services provided that they are not covered by either MassHealth Limited or MassHealth Healthy Start.

CenterCare

CenterCare enrollees use a CHC as their primary care provider. Since CenterCare is not a MassHealth program they will not be listed on REVS. To determine eligibility, the provider must complete the MassHealth application process with the patient.

Other Non-MassHealth Eligibility and HSN Secondary Eligibility

REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care Options, DMH programs, and pharmacy programs. For example, a patient in the REVS system with the restrictive message of “Mental Health Services Only” is in REVS due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility and does not imply that the HSN can be billed for services not covered by other insurance or programs.

To determine eligibility for MassHealth / Low Income Patient status, patients enrolled in these programs must complete an MBR or Virtual Gateway application.

HSN Partial Deductibles for CMSP patients between 201 - 400% FPL

If a patient is known to be a Partial Low Income Patient, and the exact income / family size of the family can be determined, the provider must calculate the co-pay and/or deductible using the formula found at 114.6 CMR 13.04 as shown as Sec. 1.3.4 of this document. In addition, providers should always check all members of the family in REVS to see if a family deductible amount is present. If a family deductible can be ascertained using REVS, it should be used. Providers may also ask if the patient has their MassHealth determination letter which will reflect their deductible amount. Otherwise providers may calculate a deductible for Partial Low Income Patients as though their income was equal to 201% FPL.

If the family size and income cannot be determined from other sources, those CMSP patients seeking services at a CHC are to be assessed a sliding scale fee as though their income were equal to 201% FPL.

Specific deductible amounts for 201% FPL in 2007 are reflected below.

Family Size	201%	Deductible
1	$20,526	$41
2	$27,521	$55
3	$34,516	$69
4	$41,511	$83
5	$48,505	$97
6	$55,500	$110
7	$62,495	$124
8	$69,490	$138

HSN Partial Deductibles for Commonwealth Care patients between 201 - 300% FPL

Commonwealth Care patients between 201% and 300% FPL must pay an HSN – Partial deductible before having their services paid for by the Health Safety Net. Due to programming difficulties in MA-21, it is currently not possible to calculate a deductible for each individual. Therefore, for Commonwealth Care patients between 201% and 250% FPL, this deductible is $41 per eligibility period. For patients between 251% and 300% FPL, this deductible is $2,083 per eligibility period.

For patients eligible for Commonwealth Care, the eligibility period is ten days prior to the date of application for benefits to one year after that date.* The deductible applies both when an individual is eligible for all HSN services before they are covered by Commonwealth Care, and when an individual is eligible for HSN dental services after their Commonwealth Care coverage is effective. See sections 2.4.4 and 5.3.2 for more information regarding HSN partial deductibles and eligibility periods.

*Important Note About the Eligibility Period: As of October 2007, REVS displays HSN – Partial deductibles for Commonwealth Care patients over 200% FPL. Please be advised that the one-year period for the deductible begins when the patient's eligibility became effective, not when the HSN – Partial deductibles began to display in REVS. This means that the one-year period

during which these patients accumulate a partial deductible should be counted beginning 10 days prior to the date of application.

2.4 HSN Eligibility Re-determination

2.4.1 New Income Documentation, HSN - Partial Deductible

Whenever a patient reports a change in circumstances, such as a change in family size or income, a re-determination can be completed using the MassHealth application process. New determinations, including new HSN - Partial deductible amounts are possible. If the patient has bills being applied to a deductible from a previous determination, they can be applied toward the new deductible.

2.4.2 MassHealth Re-Determinations and Notices

When a MassHealth or HSN patient receives a re-determination that results in no coverage change, and there has not been a gap in coverage, the eligibility begin date for that patient does not change.

For example, if a patient with HSN – Primary, determined on December 15, 2007, completes his/her eligibility review form and receives a re-determination one year later for continued HSN – Primary eligibility, the notice will show the benefit effective date as December 15, 2007, not December 15, 2008. This is because there was no coverage gap or change in eligibility. If this patient's re-determination results in a change to MassHealth Standard coverage, a new benefit effective date will apply.

2.4.3 Re-determination and Eligibility Period

A re-determination due to a change in financial circumstances or family size does not trigger a new eligibility period. If the new information (new pay stubs, for example) results in no change to the eligibility category, then the eligibility dates remain the same and the patient will not receive a MassHealth notice. If the MassHealth / HSN status is upgraded, downgraded, or terminated, then the patient receives a MassHealth notice and the "benefit effective date" changes. However, this does not mean that the patient receives a "new" one-year eligibility period. The timing of the annual review does not change because the "review date" is based on the date of initial application.

Low Income Patients who have had their status determined through the MassHealth process should follow the MassHealth processes and procedures for submitting changes. They are required to contact MassHealth regarding any changes in income, family size, employment, disability status, health insurance, and address within 10 days or as soon as possible.

2.4.4 Termination from HSN

If a patient does not respond to the annual review process at MassHealth, and is consequently terminated from MassHealth, they cannot be determined a Low Income Patient, nor will they "default" into the HSN. Patients applying for the HSN must first be screened and/or enrolled in MassHealth prior to applying for HSN. If the patient completes the required information, the patient may be appropriately determined for MassHealth and HSN.

Low Income Patients whose eligibility is determined through the MassHealth application process (MBR or Virtual Gateway) are subject to the review procedures of MassHealth. These patients must comply with the review process to retain their Low Income Patient status.

2.4.5 Failure to Pay MassHealth or Commonwealth Care Premiums

Patients who lose MassHealth or Commonwealth Care coverage due to failure to pay premiums are not eligible to have their services reimbursed by the HSN. If a patient's eligibility category comes with HSN – Secondary eligibility, the patient must re-enroll in the MassHealth or Commonwealth Care program for which the patient is eligible before the patient's services may be billed to the HSN.

3. ELIGIBLE SERVICES

New

Co-Payments for Medicare Patients also Enrolled in a Private (non-Medigap) Plan

HSN pays for these co-payments for eligible patients. For prescription drugs, providers may submit the co-pay amount to POPS for reimbursement from HSN. For other services, providers must bill Medicare and pursue Medicare bad debt where appropriate before submitting the claim to HSN.

3.1 HSN Eligible Services: The Basics

3.1.1 Overview of Eligible Services

Providers are allowed to bill the HSN for eligible services provided to Low Income Patients as defined in 114.6 CMR 13.03.

Services reimbursable by the Health Safety Net are limited to services available to MassHealth Standard members. Prescription drugs that are not included in the MassHealth preferred drug list require prior authorization through a Drug Utilization Review process. The Health Safety Net does not require prior authorization for other services for which MassHealth may require prior authorization. However, providers must use clinical judgment to decide whether these services are medically necessary. All claims submitted to the HSN are subject to audit.

The Health Safety Net will pay for services with a specific code listed in Subchapter 6 of the MassHealth Inpatient and Outpatient Provider Manuals, and for Services provided in accordance with the Health Safety Net Provider Manual. The HSN will pay for deductibles and coinsurance, but not co-payments, required by a private insurance plan.

The Health Safety Net does not pay for any of the following services: non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre-and post-sex-reassignment surgery hormone therapy; the provision of whole blood except for the administrative and processing costs associated with the provision of blood and its derivatives; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); vocational rehabilitation services; sheltered workshops; recreational services; life-enrichment services; alcohol or drug drop-in centers; drugs used for the treatment of obesity; cough and cold preparations; hormone therapy related to sex-reassignment surgery; drugs related to the treatment of male or female infertility; absorptive lenses of greater than 25 percent absorption; photochromatic

lenses, sunglasses, or fashion tints; treatment of congenital dyslexia; extended-wear contact lenses; invisible bi-focals; and the Welsh 4-Drop Lens.

3.1.2 Co-Payments Required by Private Medigap Plans

For patients eligible for the Health Safety Net, HSN pays as a secondary payer for co-payments required by Medigap plans.

3.1.3 Co-Payments for Medicare Patients also Enrolled in a Private (non-Medigap) Plan

HSN pays for these co-payments for eligible patients. For prescription drugs, providers may submit the co-pay amount to POPS for reimbursement from HSN. For other services, providers must bill Medicare and pursue Medicare bad debt where appropriate before submitting the claim to HSN.

3.2 Critical Access Services Provision Billing, Eligibility, etc.

3.2.1 Critical Access Services

Critical Access Services are defined in the regulations at 114.6 CMR 13.03(3)(b).

> ***Time of Day Clarification***
> Time of day is not a factor in the determination of critical access services. If urgent care, as defined in the regulation, is needed, it may be provided at a hospital.
>
> ***Can providers bill a Patient who would like to continue to see their current doctor at a hospital instead of receiving primary care at a CHC?***
> Providers may not bill Low Income Patients except for MassHealth and HSN co-pays and deductibles, and any non-medically necessary services that the patient has agreed to receive.

3.2.2 Psychiatric Treatment (Outpatient)

Psychiatric treatment by a specialist is a Critical Access Service.

3.2.3 Ancillary Services on a Hospital Campus (Radiology, Laboratory)

These are Eligible Services and therefore may be billed to the HSN.

3.3 Specific Services

3.3.1 Family Planning or Contraceptive Services

Family planning services are only eligible HSN services if they are eligible services according to HSN regulations. The following services would be eligible to be billed to the HSN.

- Contraceptives that are covered by the MassHealth Standard benefit are reimbursable by the Health Safety Net. If a particular contraceptive requires prior authorization under MassHealth Standard, it also requires prior authorization for reimbursement from the Health Safety Net.
- The Health Safety Net will pay for first and second trimester abortions performed by a licensed physician only when the abortion is performed in accordance with M.G.L. c. 112, §§ 12K through 12U, and the abortion is medically necessary, according to the medical judgment of a licensed physician in light of all factors affecting the woman's health. All providers are subject to audit and should keep documentation in each patient's file to demonstrate medical necessity.
- Fertility services may not be billed to the HSN.

Family planning services for low-income men, women, and children may be available in your community. Providers or patients can contact the Massachusetts Department of Public Health Family Planning Program at 617-624-6060 or toll-free at 877-414-4447 for more information.

3.3.2 VNA and Hospice Services

Home health, VNA, and hospice services are not Eligible Services per regulation 114.6 CMR 13.00 even though they are included in the MassHealth Standard benefit package. The regulation specifically excludes these services because the Health Safety Net is only able to reimburse providers for services provided at Hospitals and CHCs. Therefore, home health, VNA, and hospice services may not be billed to HSN.

3.3.3 Ancillaries and Primary Care Visits

Community health centers and acute care hospitals exempt from the Critical Access provision may submit claims for certain ancillary services associated with a primary care visit. Non-exempt hospitals may not submit claims for ancillary services associated with a primary care visit unless such visit is eligible for payment from the HSN under the Critical Access criteria.

3.3.4 Evaluation and Management Visits

This term (found in 114.6 CMR 13.03(4)(a)(2)) refers to services provided to CHC patients at an acute hospital. Reimbursing for these visits provides payment to a CHC when a CHC doctor provides services to a patient at a hospital when necessary.

3.3.5 HIV Counseling

HIV counseling may be billed under code 99402 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes (HIV pre- and post-test counseling), which falls under the "wellness" category of services as listed in Attachment A. HIV counseling is not billed as a regular outpatient counseling visit.

3.4 Medical Hardship

3.4.1. Medical Hardship Overview

The new Health Safety Net regulation, effective October 1, 2007, includes new standards for calculating whether a patient qualifies for medical hardship assistance from the Health Safety Net. Medical Hardship is a one-time determination and takes into account past medical expenses; it is not an ongoing eligibility category. Individuals applying for Medical Hardship must complete a medical hardship application at a provider site and provide any necessary documentation. Medical Hardship applications will be received and processed at the Division of Health Care Finance and Policy. Applications and instructions are available to providers on the DHCFP INET Secure Website. Patients may access these materials at hospitals and CHCs.

3.4.2 Patient Medical Hardship Contribution

In order to qualify for medical hardship assistance, a family's Allowable Medical Expenses must exceed the percentage of gross income listed in the chart below. The medical hardship qualification criteria do not take assets into consideration. There is also no income limit for medical hardship eligibility.

Income Level	Percentage of Gross Income
0 - 200% FPL	10%
201 - 300% FPL	15%
301 - 400%	20%
401 - 600% FPL	30%
>601% FPL	40%

The applicant medical hardship contribution is equal to the amount of income that the applicant's Allowable Medical Expenses must exceed in order for the applicant to qualify for medical hardship.

3.4.3 Allowable Medical Expenses for Medical Hardship

Allowable Medical Expenses include unpaid bills from medical providers that, if paid, would qualify as tax-deductible for federal income tax purposes. These bills must already have been incurred at the time of application and may have dates of service up to 12 months prior to the date of application. Allowable Medical Expenses are not limited to bills for HSN reimbursable services and may include bills for services such as private physician visits and laboratory tests that are not eligible for HSN reimbursement. Although bills that are not eligible for HSN reimbursement may be used to determine whether an individual has met the threshold for Medical Hardship eligibility, the HSN is only able to pay for services described as Reimbursable Services 114.6 CMR 13.03(2), 13.03(3), and 13.03(4).

If a patient's medical expenses include bills that are not eligible to be paid by the Health Safety Net, these bills will be counted toward the patient's Medical Hardship contribution first. If these bills do not meet or exceed the contribution amount, bills for HSN eligible services will be counted toward the contribution amount.

3.4.4 Medical Hardship Applications when a Patient can Anticipate Future Medical Bills

Example: A patient who is only eligible for medical hardship and who has had an inpatient stay at a hospital is told to come back for follow-up visits for the next 6 months. The provider and the patient wonder whether they complete a Medical Hardship application for the hospital stay only, and then complete another after the 6 months of visits, or whether should they wait until after 6 months to apply for Medical Hardship.

In this case, it would make sense for the patient to wait until after his or her foreseeable medical expenses have already been incurred to submit the application.

3.4.5 Medical Hardship Claims

Medical Hardship claims will be submitted on the 837 form, but only after the patient has been approved for medical hardship. Medical Hardship eligibility will be checked after the patient has submitted the application and approved. The claim will include information flagging the claim as Medical Hardship and will then be matched to Medical Hardship applications for eligibility.

3.4.5 Medical Hardship Claims Subsequently Eligible for Reimbursement by another Payer

Example: A patient has applied for medical hardship, and later ends up becoming eligible for SSI, and this coverage goes back retroactively prior to the date of the Medical Hardship application.

If the new payer will pay for bills that were paid by the HSN in a Medical Hardship determination, the provider should void out the bills submitted to HSN and submit them to the new payer. HSN is always the payer of last resort.

The provider may also get reimbursed by the patient's new insurance for portions of the bills that were paid by the patient. In this case, it is between the hospital and the patient to determine the most appropriate course of action.

3.4.6 Medical Hardship and Citizenship & Identity

While U.S Citizenship is not required for Medical Hardship assistance, Massachusetts residency is required. The HSN will require documentation of residency with the application. Unlike MassHealth, the HSN will not be using the postal system to verify an identity an address or residency.

There is no restriction preventing a person from applying for medical hardship while their eligibility for other programs is pending due to citizenship and identity verification.

3.5 Other

3.5.1 Commonwealth Care Members with No Dental Coverage

Providers may bill the HSN for eligible dental services provided to Commonwealth Care members and to MassHealth members eligible for HSN – Secondary if those services are not covered the member's health plan.

Prior to 10/1/07, Commonwealth Care patients received UCP "wrap." As of 10/1/07, patients enrolled in Commonwealth Care are only be eligible to receive dental services from HSN, regardless of when their eligibility was determined.

3.5.2 HSN Billable Services for MassHealth Members

Services covered by MassHealth Standard may be billed to the HSN for MassHealth members enrolled in limited benefits plans (all plans *except* MassHealth Standard, CommonHealth, Essential, Basic, and Family Assistance/Direct Coverage).

3.5.3 MassHealth PCCs and Billing the HSN for other Non-Covered Services

Providers may not submit claims to the HSN for MassHealth members who receive services at a PCC that is not their designated PCC.

4. REVS QUESTIONS

4.1 Basics

4.1.1 REVS Checks

Low Income Patient status can be checked using REVS. REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then an HSN message will be visible. The provider may bill the HSN for Eligible Services rendered to a Low Income Patient that are not covered by any other insurance or benefit.

4.1.2 Statewide Determinations, REVS and HSN

Low Income Patient and MassHealth determinations are accessible through REVS and participating providers throughout the state are able to verify patient status through REVS.

REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then a HSN message will be visible. Once a patient is determined eligible for a MassHealth aid category that implies HSN eligibility (MassHealth Limited, EAEDC, Prenatal, Healthy Start, Healthy Start plus Limited, CMSP, CMSP plus Limited, Family Assistance/Premium Assistance, Medicare Buy-In, or Senior buy-In), providers can bill the HSN services not covered by MassHealth, other insurance, or another program without any additional determinations or applications.

4.1.3 REVS and HSN Secondary

If a patient's richest aid category is HSN, the aid category will either display as "Hlth Safety Net" (if the patient's income is below 201% FPL) or "HSN Partial" (if the patient's income is between 201 and 400% FPL). If a member has other primary insurance, REVS will display a message stating that if a patient is enrolled in other health insurance, that insurance must be billed before billing the HSN.

4.1.4 "ZZ" numbers in REVS

The ZZ number is a member ID that is generated when an individual does not have a social security number (SSN).

If a patient does not have an SSN, then a REVS check using name and DOB will result in a response that does not include a field for SSN. The response will include the field "Member ID" for the ZZ number.

4.1.5 Permission to Share Information (PSI) Forms and Notification of Status

Before a patient can submit an application through the Virtual Gateway (VG), he/she must sign a permission to share information (PSI) form that allows the provider to process the application. Both the patient and the provider named on the PSI form will receive letters from MassHealth notifying them of the outcome of the determination. If the applicant uses the paper MBR, the provider will only get a letter if the patient fills out a PSI and requests that a letter be sent to the provider. PSIs are required for the Virtual Gateway common intake application. PSIs are not required for paper MBRs, but patients have the option to fill them out.

5. BILLING QUESTIONS

NEW

Eligibility Re-determinations and the HSN – Partial Deductible

If a patient's HSN deductible is lowered or becomes $0 as a result of a redetermination, the deductible amount for which the patient was responsible may no longer be billed to HSN; the patient is still responsible for the deductible amount. Patients who remain eligible for HSN, MassHealth, or Commonwealth Care are exempt from collection action and may not be billed for any amount greater than their current HSN deductible amount until they are no longer eligible for HSN, MassHealth, or Commonwealth Care.

HSN Co-Pays

Patients eligible for the HSN will be responsible for co-payments for certain services beginning on March 3, 2008.

Billing Period

Important Note about Retroactive Billing for MassHealth Essential Patients: Due to technical constraints, REVS is unable to display 10 days of retroactive HSN eligibility for MassHealth Essential patients. Until this issue is resolved, claims from dates of service beginning 10 days prior to the patient's date of application may still be billed to HSN, even though REVS may not indicate that the patient was eligible for HSN on the date of service. The date of application is available in My Account Page (MAP). If providers need further assistance determining whether a claim is eligible for HSN reimbursement, they may call the HSN helpline at 877-910-2100.

5.1 Documentation Requirements (General)

5.1.1 HSN Determination, Documenting

If the patient has applied for HSN through the MassHealth application process and appears on REVS, the provider can keep a REVS print out documenting MassHealth/Low Income Patient status on the date of service in question.

5.1.2 Partial HSN Deductible, Documenting Fulfillment of

Without proof that an individual has met his/her HSN - Partial deductible, claims for services cannot be written off to the Health Safety Net. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using HSN services, or if patients are using more than one medical facility to receive their care. REVS will not be updated

to reflect the current amount owed toward the deductible, nor will it reflect when the deductible is met.

5.2 MassHealth / Commonwealth Care / DMH Related

5.2.1 Services Not Covered by MassHealth & HSN Billing

When a patient is enrolled in a MassHealth limited benefit plan (MassHealth Limited, EAEDC, Prenatal, Healthy Start, Healthy Start plus Limited, CMSP, CMSP plus Limited, Family Assistance/Premium Assistance Medicare Buy-In, or Senior buy-In), providers can bill the HSN for Eligible Services that are not covered by the member's MassHealth plan without any additional determinations or applications. Patients enrolled in MassHealth full benefit plans (MassHealth Standard, CommonHealth, MassHealth Basic, MassHealth Essential, or Family Assistance/Direct Coverage) are not eligible to have services paid for by the HSN.

Payment by the HSN for services rendered to patients not covered by MassHealth, other insurance, or programs is as follows:

- MassHealth co-pays may not be billed to the HSN
- MassHealth deductibles may not be billed to the HSN
- Services not covered by a member's MassHealth program, but that are covered by MassHealth Standard, may be billed to the HSN.

5.2.2 Service Not Covered by Commonwealth Care & HSN Billing

Patients enrolled in Commonwealth Care may have only eligible dental services billed to the HSN. Non-dental services may not be billed to the HSN for Commonwealth Care patients, even if the services are covered by MassHealth Standard.

5.2.3 MassHealth PCCs and Billing the HSN for other Non-Covered Services

Providers may not submit claims to the HSN for MassHealth members who receive services at a PCC that is not their designated PCC.

5.2.4 REVS Message "Mental Health Services only; not Eligible for MassHealth." Billing HSN for Non-Mental Health Services

REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care Options, DMH programs, and pharmacy programs. This patient is in the REVS system due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility. Low Income Patient status is not implied by a patient's eligibility in these programs.

To determine eligibility for MassHealth / Low Income Patient status, the provider would have to do a separate MassHealth application through the Virtual Gateway or using the paper MBR.

5.2.5 Multi-Visit Procedures

Hospitals must bill the Health Safety Net at each stage of a multi-visit procedure.

For information about multi-visit procedures at Community Health Centers, see section 6.2.

5.2.6 Billing for Inpatient Stays that Began Prior to 10/1/07 and Ended After 10/1/07

Providers may either split the bill or submit the entire bill at the end of the patient's stay. Providers should keep in mind that if the entire visit is billed at the end of the patient's stay, the claim will be paid based on reimbursement rules that went into effect on October 1.

5.2.7 Settlements

Balances of bills covered by funds from settlements may still be billed to the HSN. There has been no change to these rules.

5.3 HSN Co-Pays

5.3.1 HSN Co-Pays

Patients eligible for the HSN will be responsible for co-payments for certain services beginning on March 3, 2008. At hospitals, co-payments are $5 for an outpatient visit, and $50 for an emergency room visit or an inpatient admission (the emergency room visit co-payment is waived if the visit results in an inpatient admission). Pharmacy co-payments are $1 for generic drugs and $3 for single-source drugs.

There are no co-payments for services provided to minors under the age of 19. Individuals with a family income of under 101% FPL or over 200% FPL do not have to pay co-payments, except for prescription drug co-payments. There are also no co-payments at community health centers, hospital licensed health centers, satellite clinics, with the exception of co-payments for prescription drugs.. There are no routine outpatient co-payments at hospitals exempt from the Critical Access Services Provision; the $50 emergency room visit and $50 inpatient co-payments apply, as do co-payments for prescription drugs.

There is an annual cap on co-payments (including co-payments for prescription drugs) of $250 individuals under 201% FPL. It is the responsibility of the patient and the provider to track co-payments to determine whether the patient has incurred more than the $250 annual co-payment limit.

These co-payment amounts apply to all HSN patients, regardless of their eligibility determination date. Patients determined eligible for HSN prior to October 1, 2007 will have to pay co-pays beginning on March 3, 2008.

5.3.2 Co-payments for HSN – Secondary Patients

If the Health Safety Net is paying for a deductible or for co-insurance required by an HSN – Secondary patient's primary payer, the patient is not responsible for any additional HSN co-payments for non-pharmacy services. If the Health Safety Net is paying for an HSN – Secondary patient's claim because the primary payer does not cover the service, the patient is responsible for any applicable HSN co-payments for non-pharmacy services.

Pharmacy co-payments apply regardless of whether HSN is the primary or secondary payer on the claim.

5.3.3 HSN Co-Pays and Ability to Pay

The decision to provide services to a patient that does not pay a co-payment is between the patient and the provider. Providers need to evaluate such factors as their own EMTALA status, the nature of the services being provided, or grants the provider may receive that may require serving all regardless of ability to pay, in order to determine their obligation to provide services to patients who do not pay their co-payments.

5.4 HSN Partial Deductible

5.4.1 Proof of Meeting HSN – Partial Deductible

Without proof that an individual has met his/her Partial HSN deductible, claims for services cannot be written off to the Health Safety Net. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using HSN services, or if patients are using more than one medical facility to receive their care.

5.4.2 Proof of Meeting the HSN – Partial Deductible - Continued

A patient with HSN - Partial has a deductible amount based on his/her family income which must be met each year of eligibility before he/she is eligible to have eligible services reimbursed by the HSN. Unfortunately, since REVS does not display the eligibility start date or track a patient's deductible, it is difficult to know when a partial HSN patient has met his/her deductible. In order to establish the time period for the deductible, the patient may provide a copy of their HSN determination letter from MassHealth. Providers must always check REVS to determine a patient's eligibility on a particular date of service, but may, in general, apply any applicable bills with dates of service during the eligibility period to the patient's HSN deductible (the eligibility period is six months prior to the determination date to one year after that date). The anniversary of that date may be used as a proxy for a new 1-year eligibility period, and the patient's

deductible must be satisfied again. Bills prior to the eligibility period may not be applied to the HSN deductible. In addition, a single bill may not be applied to deductibles in separate eligibility periods.

If the patient has proof of a lower deductible amount, or REVS reflects a different deductible amount than the amount reflected on a MassHealth determination letter, the new deductible amount should be used.

The provider must make every effort to determine the patient's eligibility start date. They must instruct the patient to call their MEC and request a copy of their determination letter if necessary. If a provider has a valid Permission to Share Information (PSI) form signed by the patient, the provider may contact MassHealth for the eligibility start date.

Providers must also explain to patients how they can document that they have incurred expenses that meet the deductible (i.e., copies of applicable medical bills.)

5.4.3 Prior Medical Bills and Meeting HSN – Partial Deductible

HSN – Partial patients are responsible for the HSN – Partial deductible for services provided during their retro period. Patients can apply prior paid medical bills to their HSN deductible if those services meet the criteria of Eligible Services, and were provided to the patient (evidenced by date of service) during the period during which they are determined to be Low Income Patients. The eligibility period for patients determined to be Low Income Patients is from 6 months prior to the date of determination through one year after the date of determination.

Bills incurred before the eligibility period are not eligible for use against the HSN – Partial deductible.

5.4.4 Eligibility Re-determinations and the HSN – Partial Deductible

If a patient's HSN deductible is lowered or becomes $0 as a result of a redetermination, the deductible amount for which the patient was responsible may no longer be billed to HSN; the patient is still responsible for the deductible amount. Patients who remain eligible for HSN, MassHealth, or Commonwealth Care are exempt from collection action and may not be billed for any amount greater than their current HSN deductible amount until they are no longer eligible for HSN, MassHealth, or Commonwealth Care.

5.4.5 HSN – Partial Deductible and Community Health Centers

When a Partial HSN patient receives services at a Community Health Center (CHC), the CHC uses the patient's income information to calculate, on a sliding fee scale basis, the percentage of the fee for which the patient is responsible. Once that percentage has been established, the patient is responsible for that percentage of the fee every time s/he receives CHC services until such time as s/he meets the deductible amount. The CHC may bill the remainder of the CHC fee to the HSN. See Section 6.1.1 for more information about the HSN – Partial deductible at CHCs.

5.4.6 MassHealth Spend-downs and HSN – Partial Deductibles

If a patient must meet both a MassHealth spend down and an HSN deductible the patient may use the same expenses towards meeting both the spend down and the deductible -- as long as the expenses used to count towards the HSN deductible were for eligible services as defined under 114.6 CMR 13.00.

NOTE: A Low Income Patient CAN use these bills to meet the Medical Hardship contribution.

5.4.7 HSN Co-Payments and the HSN – Partial Deductible

HSN co-payments may not be counted toward a patient's HSN – Partial deductible.

5.5 Retroactive Billing Period

5.5.1 Billing Period

With the exception of patients eligible for or enrolled in Commonwealth Care, MassHealth Basic, and MassHealth Essential, the regulation allows providers to bill to the HSN for services provided to patients eligible for HSN reimbursement up to 6 months prior to the date of application. Providers may submit claims for services provided to patients eligible for or enrolled in Commonwealth Care, MassHealth Basic, and MassHealth essential up to 10 days prior to the date of application.

Claims must be submitted within the following timeframes:

1. Unless otherwise specified below, claims must be submitted to the Health Safety Net within 90 days from the date of service (if HSN is the primary payer) or the date of the primary insurer's explanation of benefits (if HSN is the secondary payer). If a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.
2. If the Health Safety Net is the primary payer, and Low Income Patient status is determined after services are provided, claims must be submitted within 90 days of Low Income Patient determination
3. Claims for Emergency Bad Debt may be submitted no earlier than 120 days after services are provided.
4. Medical Hardship claims must be submitted within 30 days after eligibility is determined.
5. Hospital Outpatient Pharmacy claims must be submitted to POPS within 90 days after services are provided.

Important Note about Retroactive Billing for MassHealth Essential Patients: Due to technical constraints, REVS is unable to display 10 days of retroactive HSN eligibility for MassHealth Essential patients. Until this issue is resolved, claims from dates of service beginning 10 days prior to the patient's date of application may still be billed to HSN, despite the fact that REVS may not indicate that the patient was eligible for HSN on the date of service. The date of

application is available in My Account Page (MAP). If providers need further assistance determining whether a claim is eligible for HSN reimbursement, they may call the HSN helpline at 877-910-2100.

5.5.2 Retroactive Billing Deadlines if Eligibility is Unknown at Time of Service

If a patient has no eligibility determination at the time of service and the patient is subsequently determined to be eligible for HSN, bills must be submitted for dates of service before the patient's eligibility determination within 90 days of the eligibility determination. It is the responsibility of the provider to check REVS periodically to see if the patient has become eligible for the Health Safety Net. Once the patient is determined to be eligible for HSN, services provided to that patient at any time may not be billed to ER Bad Debt or Urgent Bad Debt.

5.5.3 EOB Dates far from the Date of Service

In certain situations such as automobile accidents, the Explanation of Benefits from a primary payer on a patient's claim may occur long after the date of service. In situations where a provider cannot find out whether the Health Safety Net will be the primary or secondary payer on a patient's claim, providers may submit the claim to the HSN as if HSN were the primary payer. If the claim becomes eligible for payment from another payer in the future, the provider must void the claim (or the portion of the claim eligible for payment from the other payer) submitted to the Health Safety Net.

5.6 Residency Requirements

5.6.1 Residency Requirement and Billing ER and Urgent Bad Debt

ER and Urgent Bad Debt may be billed for unpaid services provided to patients regardless of residency. However, if Massachusetts residency is established, providers are required to check REVS prior to writing off ERBD claims to the HSN in order to ensure that the patient does not have MassHealth, Commonwealth Care, or HSN. This requirement is designed to prevent ERBD claims that could be covered by another payer.

5.7 Billing Low Income Patients

5.7.1 Charges Billable to Low Income Patients

Regulations prohibit providers from billing Low Income Patients for HSN eligible services (114.6 CMR 13.08(3). Even services provided before the eligibility period – such as services provided before the 6 month retroactivity period – cannot be billed to Low Income Patients.

Patients may be billed for co-pays and deductibles required under MassHealth; Commonwealth Care; Emergency Aid to the Elderly; the Disabled and Children program (EAEDC); the Healthy Start program; the CenterCare program; or CMSP, co-pays (but not co-insurance or deductibles)

required under private insurance; HSN co-pays and deductibles; Non-HSN Reimbursable Services provided to HSN patients at the patient's request may be billed to them, provided that the patient has agreed to be responsible for paying for these services.

5.8 Other

5.8.1 Deposits

Deposits are allowed for HSN – Partial and Medical Hardship. Per regulation 144.6 CMR 13.08 (1)(f), deposits for HSN – Partial patients must be limited to 20% of the deductible, up to $500; deposits for Medical Hardship patients must be limited to 20% of the medical hardship contribution, up to $1,000.

5.8.2 Billing the HSN for EMTALA Level Screening

Emergency level screening is an Eligible Service which may be billed to the HSN provided that the patient has been determined to be a Low Income Patient. If the patient is not determined to be a Low Income Patient, providers must follow the appropriate ERBD collection requirements prior to submitting the claim for screening to the HSN.

5.8.3 Pharmacy at an Affiliated HLHC

Because the individual writing the prescription at the HLHC is affiliated with the hospital, and operating under the hospital's license, the prescription may be billed to the HSN.

5.8.4 Noticing Requirement

In all written notices to HSN patients, providers must inform them that if they do not pay for services and the services are billed to the Health Safety Net, some medical billing information, or medical billing information of family members who are spouses or dependents, may be shared with the patient's employer.

Suggested language for this notice is as follows: "The Health Safety Net Office may notify your employer or the employer of any family member if you, your spouse, or your dependents receive services from hospitals and community health centers paid by the Health Safety Net in accordance with 114.6 CMR 13.00." Providers may also use other language that conveys the same information.

6. CHC QUESTIONS

NEW

Dental Enhancement Fee

CHCs may bill the dental enhancement fee (D9450) under the same circumstances and rules that they would bill MassHealth. It may be billed once per day in conjunction with dental procedures performed. For multi-visit dental procedures, the dental enhancement fee may be billed once per visit.

6.1 CHC General Questions

6.1.1 Partial HSN Deductibles at CHCs

At CHCs, HSN – Partial patients must pay their partial deductibles according the following sliding fee scale based on income:

Income as a Percentage of Federal Poverty Income Guidelines	Percentage of Reimbursement Amount Paid by Patient
201% to 250%	20%
251% to 300%	40%
301% to 350%	60%
351% to 400%	80%

The patient should be charged the appropriate percentage of the *reimbursement amount* for the procedure or visit. Once the percentage for which the patient is responsible has been established, the patient is responsible for that percentage of the bill every time s/he receives CHC services until such time as s/he meets the partial deductible amount. The CHC may bill the remainder of the reimbursement amount to HSN.

6.1.2 CHC Sliding Scale Payments and Inability to Determine FPL

If a Low Income Patient is determined to be an HSN – Partial patient but their specific income cannot be determined, they are to be assessed a fee on the CHC sliding scale as though their income were 201% FPL.

6.1.3 Two Medical Visits in One Day

A CHC may only bill the medical visit rate once a day for a given patient (unless a patient experiences a medical condition subsequent to the first visit that is not caused by the treatment of or related to the first visit).

For example, if a patient receives a medical visit with an MD on the same day that they receive a mammography or injection from an RN, the CHC may not bill the medical rate for both visits. The CHC may bill the medical visit as well as the procedure code for the mammography. The immunization may be billed in addition to the medical visit only if the immunization is listed in Attachment A of the HSN CHC Provider Manual.

6.1.4 Two Different Types of Visits in One Day

If a patient receives both a medical visit and another type of service (dental, mental health, etc.) in the same day, the HSN will pay for the medical visit at the Medicare FQHC rate, which includes services covered by any medical codes listed under "Medical" in Attachment A as well as any "Surgeries" that occur on the same day as the medical visit. The CHC may also bill for behavioral health, dental, laboratory, radiology (technical component) and vision services provided on the same day as a medical visit. Refer to Attachment A for other services that may be billed in addition to the medical visits when those services occur on the same day. Any codes that are not listed will be considered included in the FQHC rate.

6.1.5 Immunizations

Most immunizations that are not supplied by DPH included in the medical visit rate. There are only a few that may be billed for separately (ex. Hepatitis B, pneumococcal). These immunizations are listed in the Health Safety Net Provider Manual.

6.1.6 Claims Adjudication

Claims adjudication for community health centers will begin on October 1, 2008. However, the separate claim submission is still **required** and DHCFP will be performing analysis comparing this data with the data submitted on the Payment Request Form. It is hoped that this analysis will inform providers and the Division on how to ensure a smooth transition to claims adjudication.

6.1.7 Visual Services

Rates for prescription glasses (frames and lenses) are contained in 114.3 CMR 15.00 Visual Services. If a HSNO patient wants a more expensive frame or such non-covered features as progressive bi-focals, patients may voluntarily pay for additional non-medically necessary features, and CHCs may bill patients for these services.

6.1.8 Urgent Care Bad Debt

Urgent bad debt may be billed to the HSN by CHCs. CHC bad debt may only be billed for uninsured services that are urgent in nature. This means that services billed to bad debt must either have been provided to uninsured patients or to patients whose insurance does not cover the service. Co-pays and deductibles may not be billed to HSN bad debt.

Dental services not covered by a patient's insurance may be billed to HSN bad debt only if they are urgent in nature. Non-preventative services would not automatically qualify for HSN bad debt reimbursement.

Bills for these services must have gone under continuous collection activity for at least 120 days before they are eligible for HSN payment under the Bad Debt provisions.

6.2 CHC Dental Questions

6.2.1 Dental Enhancement Fee

CHCs may bill the dental enhancement fee (D9450) under the same circumstances and rules that they would bill MassHealth. It may be billed once per day in conjunction with dental procedures performed. For multi-visit dental procedures, the dental enhancement fee may be billed once per visit.

6.2.2 Multi-Visit Dental Procedures

Prior to October 1, 2007, the Uncompensated Care Pool accepted claims for each stage of a multi-visit procedure. As of October 1, 2007, the Health Safety Net pays for all visits included in a multi-visit procedures at one time after the last visit of the procedure is concluded.

If a procedure was started prior to October 1, 2007, and is not completed as of this date, providers should bill the Health Safety Net for all visits (both prior to and after October 1) after the service is completed. If the provider has already received payments for visits that took place prior to October 1, these payments should be credited to the current payment cycle.

If a procedure started prior to October 1, 2007 is no longer reimbursable by the Health Safety Net after October 1, the provider should seek payment for the remaining portion of the services from the patient.

6.2.3 Multi-Visit Dental Procedures and Changes in HSN Eligibility

If a patient loses HSN eligibility during the course of a multi-visit dental procedure, the provider may bill the Health Safety Net only for the parts of the procedure carried out while the patient was eligible for HSN. When the procedure is billed to the HSN, the portion of the procedure carried out while the patient was not eligible for HSN must be deducted from the claim and entered as offsetting revenue on Line 23 (Income from Grants) on the Payment Reporting Form.

6.3 CHC Pharmacy Questions

6.2.1 Pharmacy Co-pays and Partial HSN deductibles

Pharmacy co-pays cannot be counted towards a partial deductible. CHCs should not charge the patient the partial deductible for prescription drugs submitted through POPS.

6.2.2 Registering a CHC's 340B Pharmacy status with the HSN

Before a CHC can bill the HSN for prescribed drugs provided through its pharmacy, the center must email their 340B ID number, and the date upon which the CHC plans to begin billing the HSN. This information should be sent ***no more than*** 3 months before the date billing commences. Please send the registrations to Rosa Alvarado at the Division of Healthcare Finance and Policy at rosa.alvarado@state.ma.us.

7. PHARMACY QUESTIONS

NEW

Pharmacy Co-Pay Effective Dates

POPS will be adjudicating claims beginning on October 1, 2007. Beginning on March 3, 2008, POPS will adjust for co-pays in the same manner as is currently done for MassHealth.

7.1 Pharmacy Claims Submission

7.1.1 Submission of Claims for Eligible Services

Only eligible hospital and community health center pharmacies are eligible for payment by HSNO. These pharmacies will submit an HSN claim in the same manner as they would for a MassHealth claim, through POPS, using the same PCN, BIN and group number. The POPS system has all of the HSN eligible patients through MassHealth REVS. POPS will first process the claim looking for a MassHealth benefit and plan for that person. If the patient or the prescription is only HSN eligible the claim will deny. Simply re-submit (by entering that command – no other changes necessary) and the claim will be processed under the HSN.

7.2 Pharmacy Co-Pays

7.2.1 Pharmacy Co-Pay Effective Dates

POPS will be adjudicating claims, effective October 1, 2007. Beginning on March 3, 2008, POPS will adjust for co-pays in the same manner as is currently done for MassHealth.

7.2.2 Patient Refusal to Pay Pharmacy Co-Pays

HSN will be implementing co-pays for outpatient pharmacy services. The date of this implementation is to be determined, and providers will be notified as soon as the Division has finalized the date. If an HSN patient refuses to pay the co-pay, providers need to evaluate such factors as their own EMTALA status, the nature of the medication, or grants the provider may receive that require serving all regardless of ability to pay, in order to determine a response to this problem. Please note that this is a slightly different approach than for entitlement programs such as MassHeath. Co-pays will not be charged to patients under 19 or to pregnant women.

7.2.3 Pharmacy Co-Payments for HSN – Secondary Patients

All HSN patients ages 19 and over are responsible for pharmacy co-payments. These co-payments apply regardless of whether the Health Safety Net is the primary or secondary payer on the claim.

7.3 Eligible Pharmacy Claims Prior Authorization

7.3.1 Prior Authorization for Prescription Drugs

The HSN will be using the same rules as MassHealth with regard to the MassHealth Drug List, PA, and other drug management rules, such as restrictions on early refill. When a clinician is required to submit a PA request for a particular drug, he or she can use the same forms faxed to the same number as used for a MassHealth member. Below is a link to this information:

> http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Provider&L2=Insurance+(including+MassHealth)&L3=MassHealth&L4=MassHealth+Drug+List&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_pharmacy_pa_forms&csid=Eeohhs2
>
> Pharmacy overrides need to be cleared by the MassHealth DUR Program at 1-800-745-7318, using the same 4 day rule that apply to MassHealth claims.

7.3.2 Prior Authorization for Existing Prescriptions

Because all existing prescriptions will need to be entered into POPS, they will be subject to the same rules as new prescriptions. This includes prior authorization and DUR for prescriptions for drugs that are not on the MassHealth preferred drug list.

7.3.3 DUR Denials

The HSN will follow the decision of the DUR regarding HSN payment. If a provider decides to supply the drug when there has been a DUR denial, the HSN will not pay that claim.

7.3.4 Drugs not Covered by Medicare and Commercial Payers

As previously stated, HSN pharmacy claims are processed through POPS and use the POPS payment rules, including use of the MassHealth Drug List and Prior Authorization, The HSN will cover drugs for eligible patients, including those enrolled in Medicare and private insurance plans whose plans do not cover a particular drug, as long as the drug is determined payable through the POPS system. That may require submission of a PA if those rules apply. Pharmacy providers should also be aware that if the HSN is the secondary payer and there is private insurance coverage, the primary carrier must be billed first so that deductibles can accrue or in case there is co-insurance.

7.3.5 Over-the-Counter and Non-Covered Medications

The HSN scope of service regulations state that coverage will be up to the service level of MassHealth Standard. That means that any drug not covered by MassHealth will not be covered for any HSN eligible, even if they were covered under the Uncompensated Care Pool. This

includes drugs such as over-the-counter medications for coughs and colds, and any other drugs no covered by MassHealth Standard.

7.3.6 Other Medical Supplies Processed through POPS

A handful of medical supplies are paid through POPS for MassHealth members. The HSN will process these items (lancets, diabetic test strips, alcohol swabs, syringes and aerochambers) via POPS as well.

7.3.7 Non-Emergency Drug Claims for MassHealth Non-Comprehensive Benefit Patients

Non-emergency drug claims for MassHealth members in non-comprehensive plans will first be reviewed as a MassHealth claim. It will be rejected if not an allowable drug under the MassHealth benefit. The claim should then be re-submitted and it will process as an HSN benefit.

7.3.8 Pharmacy Co-Pays from Other Insurers

The Health Safety Net does not pay for co-payments from other insurance plans, except for co-payments for eligible Medicare patients. Providers may not submit ineligible co-payments to POPS for reimbursement from the Health Safety Net.

7.4 Other Pharmacy Questions

7.4.1 Temporary Approval for Patients with a Pending Eligibility Determination

The process for obtaining a temporary ID is the same one currently available through a Medicaid Enrollment Center (MEC): someone applying for MassHealth or HSN can get a temporary ID from a MEC or the enrollment worker at the provider site can contact the MEC to obtain one. This temporary number is only good for 3 days. Unless a positive determination is made for eligibility the temporary ID will expire and the person is no longer eligible. When the MEC issues a temporary MassHealth Card and member goes into a pharmacy to fill an RX, the pharmacy can fill out the form found in the link below and fax it to ACS in order to put the temporary ID number in the system.

http://www.mass.gov/Eeohhs2/docs/masshealth/pharmacy/temporary-id-card-form.pdf

7.4.2 Length of Prescription Drug Supply

POPS permits a 30-day supply of drugs to be dispensed to a patient at one time.

7.4.3 HSN Dispensing Fees

The HSN will continue the policy of paying the dispensing fee for free drugs that are available through a Patient Assistance Program sponsored by the manufacturer or through samples. The pharmacy, which must be a 340B, must administer the associated paperwork and maintain the

inventory on the products. Please note that pharmacist will have to enter an NDC that is recognized by the system with a $0 cost and that drugs that require a PA will still need to go through that process. The HSN is looking into a mechanism to automate the PA under these circumstances, if clinically appropriate. This mechanism will implemented at a later date.

7.4.4 Remittance Advices for HSN Claims

The Division (not ACS) will be supplying the remittance advices to the financial office of the provider organization. It will be the responsibility of the pharmacy to obtain copies from the provider's financial office.